☐ **APPROVED**
☐ Denied: Reason Code _____
☐ Returned/ Incomplete
RTN

NETSPAP SINGLE TRIP FORM

ALL BLANKS MUST BE ACCURATELY COMPLETED. FORMS SENT TO FIRST TRANSIT WITH BLANK SPACES WILL BE RETURNED.

First Transit
799 Roosevelt Rd, Bldg 4, Suite 200
Glen Ellyn, Illinois 60137
www.netspap.com
(866) 503-9040 Toll Free
(312) 327-3854, (312) 327-3855 Fax

Requesting Organization Information

Requesting Organization Name _____ Date & Time You Initiated Request _____ A.M. P.M.

Requesting Person's Name _____ Title/Relationship _____

Fax Number _____ Call Back Number _____

Participant Information

Participant Name _____
(Last) (First)

Recipient Identification Number (RIN) _____ Date of Birth _____

Long Term Care (LTC) Resident? NO _____ ☐ Resident of Nursing Facility (NF) ☐ Resident of Inter. Care Facility (ICF/DD – ICF/MR)

YES _____ (If LTC Resident, please mark the type of LTC.) ☐ Resident of Supportive Living Facility (SLF) ☐ Resident of CILA ☐ Resident of Sheltered Care Facility

Trip Information

Date _____ Pick-up Time _____ A.M. P.M. Appointment Time _____ A.M. P.M. Return Time _____ A.M. P.M.

☐ One Way ☐ Round Trip ☐ Other _____ If this is a correction request, write RTN of previous trip: _____

Reason for Trip

_____

(please be specific) _____

Origin – Destination Information

Origin Location Name _____ Phone Number _____

Participant's Pick-up Address _____

Pick-up City _____ County _____ State _____ Zip Code _____

Medical Provider Name _____ Most Direct Number to validate appointment _____

Destination Location Name _____

Drop-off Location Address _____

Drop-off City _____ County _____ State _____ Zip Code _____

Non-Emergency Transportation (NET) Provider

Company Name _____ Phone Number _____

Please answer ALL of the following questions:

How does the participant currently get to the grocery store, laundromat, church, etc.? _____

Does the participant have a car? _____ Is there a relative or friend who can take the participant to his/her appointment? _____

Is the participant able to travel by fixed route transportation (bus or train)? (If no, explain) _____

Is the participant in need of a wheelchair or stretcher (If yes, explain) _____

List any medical conditions, diagnoses, or reasons which explain the requested category of service and/or need for attendants. _____

Category of Service

(The Category of Service must meet the medical needs of the participant at the most appropriate economic level.)

☐ **Private Auto**

☐ **Fixed Route** (Bus/Train)

☐ **Service Car**
_____ Non-Employee Attendant
_____ Employee Attendant

☐ **Taxi**

☐ **Medicar**
_____ Wheelchair _____ Stretcher
_____ Non-Employee Attendant
_____ Employee Attendant

☐ **Non-Emergency Ambulance**
_____ BLS
_____ ALS
_____ Oxygen/Supplies

Agreement and Signature

I understand if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify, under penalty of perjury, that I have obtained the information on this form from the participant (or his or her representative), and the information provided is accurate to the best of my knowledge.

_____ _____
Requesting Person's Signature (Must match requesting person above) Date Signed

Revised 9/18/07